PARENT REQUEST AND AUTHORIZATION TO ADMINISTER A PRESCRIBED MEDICATION/DRUG OR TREATMENT

To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE PRESCRIBED MEDICATIONS OR TO RECEIVE TREATMENT IN SCHOOL. ALL SPACES MUST BE COMPLETED.

Name of Student _____ Address _____

School Johnstown High School Grade _____

A. I am requesting permission for my child named above to: (Check all that apply)

_X_ use or receive prescribed medication

_____ receive prescribed treatment

_____ self-administer prescribed medication(s) in my presence or that of an authorized staff member

in accordance with the authorized prescription.

B. I will assume responsibility for safe delivery of the medication/drug to school. (The medication/drug must be received by the District (i.e., the person authorized to administer the drug to the student) in the container in which it was dispensed by the prescriber or a licensed pharmacist.)

C. I will notify the school immediately if there is any change in the use of the medication/drug or the prescribed treatment. (You must submit to the District a revised licensed prescriber's statement, signed by the prescriber, if any of the information contained in the statement changes.)

D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Signature of Parent* _____ Date _____

Home Telephone _____ Work Telephone _____

*Parent, guardian, or other person having care or charge of the student.

LICENSED PRESCRIBER'S STATEMENT

To the Prescriber:

The School District requires that all of the following information be provided before it will administer medication or treatment to the student.

Name of Student _____ Address _____

School Johnstown High School Class/Grade _____

I am a licensed health professional authorized to prescribe drugs, and I have prescribed the following medication to the above named student (specify the name of the drug) _____

Date the administration of the drug is to begin _____

Date the administration of the drug is to cease _____

Specify the dosage of the drug to be administered, and the times or intervals at which each dosage of the drug is to be administered _____

Specify any special instructions for administration of the drug, including sterile conditions and storage _____

Report the following side effects (i.e., severe adverse reactions) to my office immediately _____

Prescriber's Signature _____ Telephone _____

Printed/Typed Name _____ Date _____

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above-prescribed medication(s)/treatment(s):

Staff who completed a Board of Education approved medication administration training program and licensed medical staff.

Principal